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FOR STATE
HEALTH DEPT.

TO DELIVER TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 7/59

<div>Items 20&21 Film 273 10-25-60</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>11298 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11262</div>									
1. PLACE OF DEATH e. COUNTY Cecil MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point, Maryland 46 days c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE D.C. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1358 Spring Road, N.W. d. STREET ADDRESS 47 X-3 IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) STEPHEN J. BOROWSKI, Sr. First Middle Last 4. DATE OF DEATH October 4, 19 60 Month Day Year									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/20/77		9. AGE (In years last birthday) 83 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker 10b. KIND OF BUSINESS OR INDUSTRY Poland					11. BIRTHPLACE (State or foreign country) USA 12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Frank Borowski					14. MOTHER'S MAIDEN NAME Stasia Derbiskewski				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WWI 16. SOCIAL SECURITY NO. 578148116A					17. INFORMANT Mrs. Lillian Borowski (Wife) 1358 Spring Rd., N.W., Washington, D.C.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive retroperitoneal hemorrhage DUE TO (b) Fracture of right acetabulum, result of a fall Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral arteriosclerosis, severe. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Another patient pushed him down in ward to the floor.				
20c. TIME OF INJURY Month, Day, Year 7:40 p.m. 10-3 19 60			2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) V.A. Hosp.		20f. (City or town) (County) (State) Perry Point Cecil Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>R. C. Dodson</i> EXAMINER'S NAME (Type) R. C. DODSON, M. D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/7/60		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cemetery		22d. LOCATION (City, town, or country) (State) Arlington, Virginia			
23. FUNERAL DIRECTOR The S H Hines Co.					24a. REC'D BY REGISTRAR 2901-1448122		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>		

MEDICAL CERTIFICATION

1128

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1.00

1.00

Washington

10 days

Fort Point, Maryland

15th April, 1900, N.Y.

Veterans Administration Board

October 1, 1900

Washington, D.C.

25

11/20/00

11/20/00

11/20/00

Poland

Captain Baker

Frank Horvath

Charles Delaney

William Horvath (1890)

STAN-BLOCK 1890 Spring 1890, Washington, D.C.

Yes

Warrior's record, 1890-1900

Record of 1890-1900, record of 1890-1900

General information, 1890-1900

1.00

Washington, D.C.

1.00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11281
CERTIFICATE OF DEATH

11263
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Reside before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>18 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colora.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION Hospital, ELKTON, Md.</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>ELIZABETH</u> Last <u>BRANTNER</u>		4. DATE OF DEATH Month <u>October</u> Day <u>22</u> Year <u>1960</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 14, 1898</u>	9. AGE (In years last birthday) <u>62 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Bedford, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Young</u>			14. MOTHER'S MAIDEN NAME <u>Ann Thomas</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-12-0933</u>		INFORMANT Name <u>Gene Elipson</u> Address <u>Colora, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, stomach with metastases</u> 151X DUE TO (b) <u>and liver extension</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-7</u> , 19 <u>60</u> , to <u>10-22</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>10-22</u> , 19 <u>60</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>123 Singers Ave</u> DATE SIGNED ACTUAL SIGNATURE <u>Tillman D. Johnson</u> M.D. <u>Elkton, Md.</u> PHYSICIAN'S NAME (Type) <u>Tillman D. Johnson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 25, 60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Conowings Baptist</u>		22d. LOCATION (City, town, or county) (State) <u>Conowings, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard L. Goodie</u>		ADDRESS <u>Rising Sun, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 26 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

11581

CERTIFICATE OF DEATH

1563

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11282

CERTIFICATE OF DEATH

11264
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle PERKINS Last BROWN		4. DATE OF DEATH Month October Day 3 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27, 1878
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	11. IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY at Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Perkins		14. MOTHER'S MAIDEN NAME Georgianna V. Roberts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Virginia B. Heath		Address Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Cerebrovascular Heart Disease with DUE TO Irreversible Decompenation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebrovascular Disease Generalized DUE TO Generalized (c) Generalized INTERVAL BETWEEN ONSET AND DEATH 19 days 4 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple contusion incurred by fall 9-24-60			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall, striking chest and right arm	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 9 24 1960 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Elkton Cecil Md.
21. I certify that I attended the deceased from 9-25, 1960 to 10-3, 1960 that I last saw the deceased alive on 10-3, 1960 , and that death occurred at 12:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE William D. Johnson M.D.		ADDRESS (Street, city or town, state) 123 Singlerly Ave Elkton Md	
PHYSICIAN'S NAME (Type) William D. Johnson M.D.		DATE SIGNED 10-4-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 6, 1960	22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery	22d. LOCATION (City, town, or county) (State) Elkton, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME		ADDRESS Donald H. Dee Elkton, Md	
24a. REC'D BY REGISTRAR DATE OCT 7 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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TEMPERATURE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11265

11283

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			
c. LENGTH OF STAY IN 1b 5 days							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Devine Haven Nursing Home				d. STREET ADDRESS 1113 Church Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MARY Middle A. Last BUCKWORTH				4. DATE OF DEATH Month Oct. Day 28 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 7, 1880	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Chesapeake City, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George Lusby				14. MOTHER'S MAIDEN NAME Mary Hague			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. A. Rudolph Buckworth, Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH unknown			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 15, 1960 to Oct. 28, 1960 , that I last saw the deceased alive on Oct. 28, 1960 , and that death occurred at 3:20p. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature]				ADDRESS (Street, city or town, state) 233 E. Main Street		DATE SIGNED 10/29/60	
PHYSICIAN'S NAME (Type) S. RALPH ANDREWS, JR., M.D.				Elkton		Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-31-60		22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) nr. Chesapeake City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME				ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR Oct 31 '60	
				24b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be used by the hospital or attending physician.
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11299
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
11266

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Maryland				c. LENGTH OF STAY IN 1b 6 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION V.A. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Thomas E. DASHIELL				4. DATE OF DEATH 10-4-60 19 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-16-1919	
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Emmerton, Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME CLIFFORD DASHIELL				14. MOTHER'S MAIDEN NAME Eula EULA COOK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWII				16. SOCIAL SECURITY NO. 219-05-1240			
17. INFORMANT V.A. Hospital records, Perry Point, Md.				Address			
18. CAUSE OF DEATH [Enter one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 465X IMMEDIATE CAUSE (a) Thrombosis of Pulmonary Artery, Cause Unknown Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Unknown (c) Unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from 9-28-60 19 to 10-4-60 19 that the deceased died on 10-4-60 and that death occurred at 10:30 from the causes and on the date stated above.							
22a. SIGNATURE J. L. Garey				22b. DATE SIGNED Oct. 5, 1960			
22c. PHYSICIAN'S NAME (Type) J. L. GAREY, M.D.				22d. ADDRESS VAH., Perry Point, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 8, 1960		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCATION (City, town, or county) (State) Bel Air Harford Md.,	
24. FUNERAL DIRECTOR'S SIGNATURE Howard K. McLean Jr				25a. REC'D BY REGISTRAR Abingdon		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11284
CERTIFICATE OF DEATH

11267

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Cecil</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Union Hosp</i>		d. STREET ADDRESS <i>1130 West Main</i>	
3. NAME OF DECEASED (Type or print) First <i>Maxwell</i> Middle Last <i>Davis</i>		4. DATE OF DEATH Month <i>Oct</i> Day <i>29</i> Year <i>1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 30 1902</i>
9. AGE (In years last birthday) <i>58</i> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sanitor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Hospital</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Cecil Davis</i>		14. MOTHER'S MAIDEN NAME <i>Lula Heath</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>221-03-5706</i>	
INFORMANT <i>Bessie E. Gillospie</i>		Address <i>700 Kaimosi Ave</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hepatic Failure</i> 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Portal Cirrhosis of Liver</i> (c) <i>unknown</i>		INTERVAL BETWEEN ONSET AND DEATH <i>27 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Oct 2</i> , 19 <i>60</i> , to <i>Oct 2</i> , 19 <i>60</i> that I last saw the deceased alive on <i>Oct 29</i> , 19 <i>60</i> , and that death occurred at <i>6:30</i> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wallace Shevchen</i> M.D.		ADDRESS (Street, city or town, state) <i>Cecilton, md</i> DATE SIGNED <i>30 Oct 60</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>11-1-60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Silverbrook Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Wilmington Dela</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William J. Warwick</i> ADDRESS <i>Thurmont Dela</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 7 '60</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

WILLIAM J. WARWICK

11284

UNITED STATES DEPARTMENT OF COMMERCE

OFFICE OF THE SECRETARY

11284

RECEIVED
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U.S. DEPT. OF COMMERCE

OFFICE OF THE SECRETARY

WASHINGTON, D.C.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11300 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11268

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Md. b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, R.D.3.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, R.D.3.			c. LENGTH OF STAY IN lb All life		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			e. STREET ADDRESS Elkton, R.D.3.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Herbert Middle Leroy Last Demond			4. DATE OF DEATH Month 10 Day 23 Year 19 60		
5. SEX M			6. COLOR OR RACE W		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH Dec. 8, 1878		
9. AGE (In years last birthday) 81 yrs.			IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter			10b. KIND OF BUSINESS OR INDUSTRY All carpenter		
11. BIRTHPLACE (State or foreign country) Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Joseph Demond			14. MOTHER'S MAIDEN NAME Caroline Bullen		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 215-10-7409		
17. INFORMANT Mrs. Herbert Leroy Demond, Elkton, Md.			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Arterio sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE R.C. Dodson			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) R.C. Dodson			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			DATE SIGNED 10-24-60		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 10-26-60		
22c. NAME OF CEMETERY OR CREMATORY North East Methodist Cem.			22d. LOCATION (City, town, or country) (State) North East Maryland		
23. FUNERAL DIRECTOR Joseph P. Grand			ADDRESS North East, Maryland		
24a. REC'D BY REGISTRAR OCT 25 '60			24b. REGISTRAR'S SIGNATURE Arthur S. Grand		

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11285

CERTIFICATE OF DEATH

11269

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Cecil b. COUNTY Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 131 E. Main Street		d. STREET ADDRESS 131 E. Main Street, e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EVANS Middle LOUIS Last DUNBAR		4. DATE OF DEATH Month Oct. Day 31, Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug. 4, 1887
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Moulder		10b. KIND OF BUSINESS OR INDUSTRY Foundry	11. BIRTHPLACE (State or foreign country) Newark, Del.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William C. Dunbar	
14. MOTHER'S MAIDEN NAME Emma Rambo		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. 181-01-4958		17. INFORMANT Address Md. Mrs. Lillian D. Rodgers, R. D. Elkton,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary thrombosis DUE TO (c) Coronary artery disease			INTERVAL BETWEEN ONSET AND DEATH 6 hr 6 hr years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8-1-1960 to 10-31-1960 that I last saw the deceased alive on 10-31-1960, and that death occurred at 4 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE T. D. Johnson		ADDRESS (Street, city or town, state) 123 Singer 14 Ave	
PHYSICIAN'S NAME (Type) T. D. Johnson		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-3-60	22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery	22d. LOCATION (City, town, or county) (State) Elkton Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PIPPIN FUNERAL HOME Donald H. Pippin Elkton Md.		24a. REC'D BY REGISTRAR DATE NOV 4 '60	24b. REGISTRAR'S SIGNATURE

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

11286 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

11270
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLAYTON L. ELLISON		4. DATE OF DEATH October 13 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 4, 1890
9. AGE (In years last birthday) 70		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxicab		10b. KIND OF BUSINESS OR INDUSTRY Driver	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clayton L. Ellison Sr.		14. MOTHER'S MAIDEN NAME Carrie Griffith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-10-1878	
17. INFORMANT Mrs. Clayton L. Ellison		Address Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Acute Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease (c) Cerebral Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2-3 weeks 2-3 years 11	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/4, 1960, to 10/13, 1960, that I last saw the deceased alive on 10/13, 1960, and that death occurred at 3:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Peter Stavakis		ADDRESS (Street, city or town, state) Elkton, Md.	
PHYSICIAN'S NAME (Type) Peter Stavakis		DATE SIGNED 10/13/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 16, 1960	
22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Elkton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME		24a. REC'D BY REGISTRAR DATE OCT 17 '60	
ADDRESS 24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11287

CERTIFICATE OF DEATH

11271

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD Pa</u> b. COUNTY <u>Chester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton Elverson</u>	
c. LENGTH OF STAY in 1b <u>15 YRS</u>		d. STREET ADDRESS <u>Main St 75X-5</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Devereaux Home, Elkton, Md</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>C</u> Last <u>Finger</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>5</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 6 1878</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Levi Clingaman</u>		14. MOTHER'S MAIDEN NAME <u>SUSAN Culp</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. William Fox (Daughter)</u>		Address <u>Elkton, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs</u> <u>years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 4</u> , 19 <u>60</u> , to <u>Oct 5</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Oct 4</u> , 19 <u>60</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Tillman D. Johnson</u> M.D.		ADDRESS (Street, city or town, state) <u>123 Singenly Ave</u> DATE SIGNED <u>10-5-60</u>	
PHYSICIAN'S NAME (Type) <u>Tillman D. Johnson</u>		<u>Elkton Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>OCT 8, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ELLERSON MEATH</u>	22d. LOCATION (City, town, or county) (State) <u>ELLERSON, PENNA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FUNERAL HOME</u> ADDRESS <u>Elkton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 7 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11301

11272

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 23yrs.2days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 1708 South Charles	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle EDWARD Last FORD		4. DATE OF DEATH Month October Day 16 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10-14-99
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 12 Days 16 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William E. Ford		14. MOTHER'S MAIDEN NAME Marjorie (?) Ford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mrs. Doris Shortt, daughter, 1600 Patapsco		Address St. Baltimore, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and infarct of brain, left side DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebrovascular accident DUE TO (c) Sclerosis of cerebral vessels		INTERVAL BETWEEN ONSET AND DEATH 8 days 8 days Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the deceased died on October 14, 1937 at October 16, 1960 from the causes and on the date stated above.			
22a. SIGNATURE A. L. Mooney		22b. DATE SIGNED 10-18-60	
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, Asst. Clinical Pathologist, V.A. Hospital, Perry Point, Md.		22d. ADDRESS V.A. Hospital, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 10/20/60	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City, town, or county) (State) BALTIMORE Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Winnington & Son Have & Sons Md.		25a. REC'D BY REGISTRAR DATE OCT 24 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kane			

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FOR STATE
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11288 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11273											
Item 7 Film 0273 10-19-60 at											
1. PLACE OF DEATH a. COUNTY Cecil				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN b. D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				e. STATE Md.				f. COUNTY Wicomico			
3. NAME OF DECEASED (Type or print) HILDA				First Middle Last MARIE GRAY				4. DATE OF DEATH Oct. 15, 1960			
5. SEX Female		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Aug. 31, 1915		9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baking Company				10b. KIND OF BUSINESS OR INDUSTRY Slicer				11. BIRTHPLACE (State or foreign country) Delmar, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Harrison				14. MOTHER'S MAIDEN NAME Lula Harrington							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO.				17. INFORMANT Mrs. Shirley Pinder, Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE INJURIES - LACERATED 816X DUE TO CHIN, THROAT, BREAST, RT. FOOT, HEEL DUE TO ABOVE ANKLE - CRUSHED RT CHEST - BROKEN (e), stating the underlying cause last. RT HUMERUS											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (e)											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ACCIDENT - CAR HIT TRUCK AT CECIL CO Md							
20c. TIME OF INJURY Month, Day, Year 12:45 p.m. 10-15 1960				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) RT 40 + LANDING GEAR ELKTON CECIL Md		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE R. C. Dodson				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED Oct. 15, 1960			
EXAMINER'S NAME (Type) R. C. Dodson, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal				22b. DATE THEREOF Oct. 16, 1960		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State) Salisbury, Md.			
23. FUNERAL DIRECTOR PIPPIN FUNERAL HOME				ADDRESS 1000 N. 2nd St. Elkton, Md.				24a. REC'D BY REGISTRAR OCT 19 '60		24b. REGISTRAR'S SIGNATURE Charles E. Evans	

11273 MEDICAL EXAMINER'S CERTIFICATE OF DEATH



Worcester

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Cecil

Bellevue

D.O.B.

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100 Cambridge Avenue

Union Hospital

Oct.

1910

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11

James

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Bellevue

Bellevue

James Harrison

James Harrison

Mrs. Elizabeth Benson, Boston, Mass.

Handwritten signature

James A. Benson, M.D.

Oct. 10, 1910

Bellevue

Worcester, Mass.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11302

11274

Items 3,13,17 Film 6273 10-20-60 et

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY MONTGOMERY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRYN MAWR	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 132 CLEMSON ROAD 75X-3	
3. NAME OF DECEASED (Type or print) First EDWARD Middle (NMI) Last HOLZBAUER		4. DATE OF DEATH Month October Day 10 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1892
9. AGE (In years lost birthday) 68 yrs.		IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0 IF UNDER 24 HRS. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE HOLZBAUER		14. MOTHER'S MAIDEN NAME CAROLINE KOHLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW-1		16. SOCIAL SECURITY NO. 198 07 8174	
17. INFORMANT Mrs. Edith Holzbauer (W)		Address 132 Clemson Rd., Bryn Mawr, Penna.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Severe debilitation DUE TO (c) Recurrent Brain Tumor (8th nerve tumor) left side with Hydrocephalus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Brain tumor (8th nerve tumor) 2 years ago. Craniotomy for same.		INTERVAL BETWEEN ONSET AND DEATH Unknown Unknown approx. 2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I (this hospital) attended the deceased from Sept. 30, 1960 to October 10, 1960 , that I (we) last saw the deceased alive on Oct. 10, 1960 , and that death occurred at 3:PM , from the causes and on the date stated above.			
22a. SIGNATURE Albert L. Mooney		22b. DATE SIGNED October 10, 1960	
22c. PHYSICIAN'S NAME (Type) ALBERT L. MOONEY, M.D.		22d. ADDRESS VAH., Perry Point, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-14-60	
23c. NAME OF CEMETERY OR CREMATORY MT. Vender		23d. LOCATION (City, town, or county) (State) Phila. Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE FRANKENFIELD & CHADWICK, Ardmore, Penna.		25a. REC'D BY REGISTRAR DATE OCT 13 '60	
25b. REGISTRAR'S SIGNATURE Albert S. Kline			

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• *THE UNIVERSITY OF CHICAGO*

• 11/2/2009 •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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11303
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11275

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY SV 01-4			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville				c. LENGTH OF STAY IN 1b 27 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VAH., Perry Point, Md				d. STREET ADDRESS 2411. Maryland ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDWARD Middle J Last KELLY				4. DATE OF DEATH Month October Day 29 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/25/06	
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months 34 Days 34 Hours 34 Min. 34		IF UNDER 24 HRS. Months 34 Days 34 Hours 34 Min. 34			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Clarksburg, W. Va.	
13. FATHER'S NAME Edward Kelly				14. MOTHER'S MAIDEN NAME Winifred Langan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW II 232-10-1075		17. INFORMANT Hospital records -Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sclerosis of Coronary Vessels (c) Unknown						INTERVAL BETWEEN ONSET AND DEATH 6-12 Hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 10/2/60				20g. (County) 10/29/60		20h. (State) 10/30/60	
21. I certify that (I) (the hospital) attended the deceased from 10/2/60 to 10/29/60 , and that death occurred at 10:55 from the causes and on the date stated above.							
22a. SIGNATURE A.L. Mooney				22b. DATE SIGNED 10/30/60			
22c. PHYSICIAN'S NAME (Type) Dr A.L. MOONEY, Pathologist				22d. ADDRESS VAH., Perry Point, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/1/1960		23c. NAME OF CEMETERY OR CREMATORY Holy Cross		23d. LOCATION (City, town, or county) (State) Clarksburg W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Bennig				25a. REC'D BY REGISTRAR DATE NOV 4 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11280

CERTIFICATE OF DEATH

11276

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u>		c. LENGTH OF STAY IN 1b <u>5 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Morgan Nursing Home</u>		d. STREET ADDRESS <u>14X-2</u>	
3. NAME OF DECEASED (Type or print) First <u>ELMA</u> Middle <u>L.</u> Last <u>KNAPP</u>		4. DATE OF DEATH Month <u>October</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 24, 1881</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis R. Knapp</u>		14. MOTHER'S MAIDEN NAME <u>Ann I. Pitcher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Nursing Home Records</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>450.0</u> IMMEDIATE CAUSE (a) <u>Astero Sclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sept 12</u> <u>1960</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>Sept 12, 1960</u> to <u>Sept 13, 1960</u> , that I last saw the deceased alive on <u>Sept 12, 1960</u> , and that death occurred at <u>5:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry V. Davis</u>		ADDRESS (Street, city or town, state) <u>Chesapeake City, Md</u>	
PHYSICIAN'S NAME (Type) <u>HENRY V. DAVIS M.D.</u>		DATE <u>10/14/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/17/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>HANCOCK, New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Frank</u>	
ADDRESS <u>Elkton, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	
DATE <u>OCT 26 '60</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11289

CERTIFICATE OF DEATH

11277

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 1 Day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X North East Rural	
		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOYCE First Middle Last S. LANDERS		4. DATE OF DEATH Month October Day 26 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 29, 1934
9. AGE (In years last birthday) 25 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Reg. Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Homer R. Simpson		14. MOTHER'S MAIDEN NAME Eva N. Bowersox	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Address Paul O. Landers Frederick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 642.3 Eclampsia DUE TO (b) Toxemia of Pregnancy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH 16 hours 2 wks (?)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I attended the deceased from 20 June, 1960 to 26 Oct, 1960, that I last saw the deceased alive on 26 Oct 1960, and that death occurred at 11:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 10/26/60 ACTUAL SIGNATURE Klaus H. Huebner M.D. North East, Md. PHYSICIAN'S NAME (Type) Klaus H. Huebner A.D.			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF Oct 29, 1960	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cem.		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PIPPIN FUNERAL HOME 1005 E. Elkton, Md.		24a. REC'D BY REGISTRAR DATE OCT 28 '60	
		24b. REGISTRAR'S SIGNATURE	

11880

CERTIFICATE OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11304

11278

1. PLACE OF DEATH a. COUNTY Cecil			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City R.D.1. d. STREET ADDRESS Chesapeake City R.D.1.		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chesapeake City, R.D.1. 21yrs.			c. LENGTH OF STAY IN 1b		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) James Edward Lester			4. DATE OF DEATH Month 10 Day 19 Year 60		
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-31-1939		9. AGE (In years last birthday) 21 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Elkton, Md.	
13. FATHER'S NAME Robert Lester		14. MOTHER'S MAIDEN NAME Bertha Thomas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-38-5080		17. INFORMANT Bertha Lester, Chesapeake City, R.D.1. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Epilepsy DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE R.C. Dodson		M.D. R.C. Dodson		DATE SIGNED 10-19-60	
EXAMINER'S NAME (Type) R.C. Dodson		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/23/60		22c. NAME OF CEMETERY OR CREMATORY Bohemia Manor Cem.	
22d. LOCATION (City, town, or country) Bohemia Manor, Md.		23. FUNERAL DIRECTOR Arthur R. Bell ADDRESS 909 Poplar St., Wil. Del.			
24a. REC'D BY REGISTRAR OCT 24 '60		24b. REGISTRAR'S SIGNATURE Arthur R. Bell			

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CERTIFICATE OF DEATH

11279

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Town Point, Rural Chesapeake City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Town Point, Rural Chesapeake City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lillian Middle E. Last Mayhew				4. DATE OF DEATH Month October Day 1 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 30, 1886	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 74 Days 74 Hours 74 Min.		IF UNDER 24 HRS. Months 74 Days 74 Hours 74 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Cecil Co., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Edward Whitlock				14. MOTHER'S MAIDEN NAME Sarah May			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 220-34-5955			
17. INFORMANT Mr. Elmer C. Mayhew, Rural Chesapeake City, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.2 DUE TO Chronic myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 years (c) 2 years						INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 10, 1958 to Sept 1, 1960 , that I last saw the deceased alive on Sept 30, 1960 , and that death occurred at 12:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Henry V. Davis M.D.				ADDRESS (Street, city or town, state) CHESAPEAKE CITY MD			
PHYSICIAN'S NAME (Type) HENRY V. DAVIS				DATE SIGNED 10/1/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 5, 1960		22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Chesapeake City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows, Mullington, Md.				24a. REC'D BY REGISTRAR DATE OCT 6 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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11290

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN lb 4 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton Rd 5	
3. NAME OF DECEASED (Type or print) First Middle Last Larren B. McCommons				4. DATE OF DEATH Month Day Year October 4 1960			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 30, 1874	
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paper Maker Ret				10b. KIND OF BUSINESS OR INDUSTRY Paper Mfg		11. BIRTHPLACE (State or foreign country) Chester Co., Penna	
13. FATHER'S NAME Lawson McCommons				14. MOTHER'S MAIDEN NAME Margaret Perry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. no			
17. INFORMANT Mrs Anna Brown				Address Elkton Rd 5, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cholecytosis acute 584X DUE TO Cholelithiasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Breast unknown							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Elkton				20g. (County) Cecil		20h. (State) Md	
21. I certify that I attended the deceased from Sept 8, 1960, to Oct 4, 1960, that I last saw the deceased alive on Oct 4, 1960, and that death occurred at 6:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Chesapeake City Md 10/4/60							
ACTUAL SIGNATURE Henry V. Davis M.D.				PHYSICIAN'S NAME (Type) Henry V. Davis M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-8-1960		22c. NAME OF CEMETERY OR CREMATORY Moore's Chapel		22d. LOCATION (City, town, or county) (State) Elkton Rural Cecil, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant North East, Md				24a. REC'D BY REGISTRAR DATE OCT 7 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11300

CERTIFICATE OF DEATH

11300



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH										DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH																								
1. PLACE OF DEATH a. COUNTY Cecil					b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point					c. LENGTH OF STAY IN 1b 24 days					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland					b. COUNTY Cecil				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					d. STREET ADDRESS 1 Broad Street														
3. NAME OF DECEASED (Type or print) First RALPH Middle E. Last MC CREARY					4. DATE OF DEATH Month October Day 30 Year 1960																			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 23, 1891			9. AGE (In years lost birthday) 69 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physio-therapist (Ret.)					10b. KIND OF BUSINESS OR INDUSTRY Hospital					11. BIRTHPLACE (State or foreign country) Pennsylvania					12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME Charles Mc Creary (deceased)					14. MOTHER'S MAIDEN NAME Agnes M. Walton (Deceased)																			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes					16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW-I None					17. INFORMANT 955 Georgia Ave. Silver Spring, Md. Mrs. Thelma C. Ruppert, Step-Daughter.														
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Calcification of pleura due to infection healed Years DUE TO (c) Fibrous pleurisy due to repeated pneumonia attacks										INTERVAL BETWEEN ONSET AND DEATH 2-3 weeks														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19					20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)									
21. I certify that the deceased attended the deceased from October 6, 1960, to October 30, 1960, and that death occurred at 10:47 A.M. from the causes and on the date stated above.																								
22a. SIGNATURE A. L. Mooney					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22b. DATE SIGNED 10-31-60														
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY					22d. ADDRESS Asst. Clinical Pathologist, V.A. Hospital, Perry Point, Md.																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 11-2-1960					23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery					23d. LOCATION (City, town, or county) (State) Washington 23, D.C.									
24. FUNERAL DIRECTOR'S SIGNATURE Lee & Paterson & Son					ADDRESS Perryville, Md.					25a. REC'D BY REGISTRAR DATE NOV 3 '60					25b. REGISTRAR'S SIGNATURE Arthur E. Hume									

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RECEIVED OF DATE

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11282

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perryville		c. LENGTH OF STAY IN 1b Less than 24 hrs. X		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perryville			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 1 RFD #1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last PHILIP S. MORRISON				4. DATE OF DEATH Month Day Year October 26 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-15-93	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman (retired)		10b. KIND OF BUSINESS OR INDUSTRY Penna. R.R.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Granville Morrison				14. MOTHER'S MAIDEN NAME Julia Simmers			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Sadie Morrison, wife, RFD #1, Perryville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, early 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis of coronary vessels, severe DUE TO (c) Arteriosclerosis, generalized						INTERVAL BETWEEN ONSET AND DEATH 1 day Years Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
2Da. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) R. C. DODSON				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 10-26-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-29-1960		22c. NAME OF CEMETERY OR CREMATORY West Nottingham		22d. LOCATION (City, town, or country) (State) Coloma, Md	
23. FUNERAL DIRECTOR Lee Patterson & Son, Perryville, Md.				24a. REC'D BY REGISTRAR OCT 28 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MEDICAL CERTIFICATION

THE STATE
DEPARTMENT
WASHINGTON
D. C.

11307

MINISTERS OF THE DEPARTMENT OF HEALTH
AND HUMAN SERVICES
WASHINGTON, D. C. 20492

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11283

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RISING SUN</u> RURAL				c. LENGTH OF STAY IN 1b <u>18 Months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GRAYBEAL NURSING HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>RICHARD</u> Middle <u>ELVINGTON</u> Last <u>PARKER</u>				4. DATE OF DEATH Month <u>10</u> / Day <u>20</u> / Year <u>19 60</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11 / 2 / 1866</u>	9. AGE (In years last birthday) <u>93</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER RET.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>UNKNOWN</u>			
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>219-10-8466</u>				17. INFORMANT Address <u>Mrs. B.S. Griffin Smithfield Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>5 yrs.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>8</u> <u>19 60</u> to <u>10/20</u> <u>19 60</u> that (I) (we) last saw the deceased alive on <u>10/20</u> <u>19 60</u> and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Neil Taylor Jr.</u>				22b. DATE SIGNED <u>10/21/60</u>		22c. PHYSICIAN'S NAME (Type) <u>Neil Taylor Jr.</u>	
22d. ADDRESS <u>Rising Sun, Md.</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
23b. DATE THEREOF <u>10-23-1960</u>				23c. NAME OF CEMETERY OR CREMATORY <u>WEST NOTTINGHAM CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>COLORA</u> <u>MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas E. Mullen</u>				25a. REC'D BY REGISTRAR <u>Rising Sun, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Kins</u>	
25c. DATE <u>OCT 24 '60</u>				25d. DATE <u>OCT 24 '60</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corrob. pages. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11587

11-10-62

CERTIFICATE OF DEATH

State of New York
County of New York
City of New York
I, the undersigned, being a duly qualified medical officer of health for the City and County of New York, do hereby certify that on the 10th day of November, 1962, at New York City, New York, died
Name of Deceased: [illegible]
Age: [illegible]
Sex: [illegible]
Race: [illegible]
Cause of Death: [illegible]
Place of Death: [illegible]
Signature of Medical Officer of Health: [illegible]
Signature of Registrar: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11291

CERTIFICATE OF DEATH

11284

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 458 Bow St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Jesse Middle E. Last Pierson				4. DATE OF DEATH Month 10 Day 4 Year 19 60			
5. SEX M.		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 25 1888	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Cecil County Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Edward E. Pierson				14. MOTHER'S MAIDEN NAME Emma Jane Green			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 215-32-8724		17. INFORMANT Mary M. Pierson Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis died instantly 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic coronary artery disease unknown DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov. 2 , 19 59 to Oct. 4 , 19 60 , that I last saw the deceased alive on Oct. 3 , 19 60 , and that death occurred at 10:30 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 233 E. Main Street Elkton, Maryland DATE SIGNED 10/6/60							
ACTUAL SIGNATURE S. RALPH ANDREWS, JR.				M.D. 233 E. Main Street			
PHYSICIAN'S NAME (Type) S. RALPH ANDREWS, JR.				Elkton, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/8/1960		22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cherry Hill Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Walter duBois Jr. Elkton, Md.				24a. REC'D BY REGISTRAR DATE OCT 11 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Priddy	

11309

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11285

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural			c. LENGTH OF STAY IN 1b 30 Yrs			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Ross Middle Preston Last Preston				4. DATE OF DEATH Month Oct. Day 23 Year 1960				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 17, 1876		
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer, Retired			10b. KIND OF BUSINESS OR INDUSTRY Owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Frank				14. MOTHER'S MAIDEN NAME Sloame				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 1				
17. INFORMANT Mrs Raymond H. Creswell, Port Deposit, Md				Address R F D				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Heart Disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH one hour 3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3 1960 , to 10/23 , 19 60 , that (I) (we) last saw the deceased alive on 10/23 , 19 60 , and that death occurred at 3:00 P. M. from the causes and on the date stated above.								
22a. SIGNATURE Neil R. Taylor			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/24/60			
22c. PHYSICIAN'S NAME (Type) Neil R. Taylor			22d. ADDRESS Rising Sun, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 10-26-1960		23c. NAME OF CEMETERY OR CREMATORY St. Paul		23d. LOCATION (City, town, or county) (State) Jarrettsville, Md. Rural	
24. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son			ADDRESS Perryville, Md.		25a. REC'D BY REGISTRAR DATE OCT 26 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1125

• 220

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. AISME
5M 7/59

11310
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11286

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rising Sun Rural c. LENGTH OF STAY IN 1b 43 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun Rural d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Charles Leslie Rawlings				4. DATE OF DEATH Month Day Year 10 4 1960					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-3-1886			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer		10b. KIND OF BUSINESS OR INDUSTRY Owner of Farm		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Robert Rawlings				14. MOTHER'S MAIDEN NAME Sarah Maxwell					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no				16. SOCIAL SECURITY NO. 219-36-0040					
17. INFORMANT Mary Rawlings, Part Deposit R.D. Md.				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE R.C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 10-4-60	
EXAMINER'S NAME (Type) R.C. Dodson				Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-7-60		22c. NAME OF CEMETERY OR CREMATORY W. Nottingham Cem.		22d. LOCATION (City, town, or country) (State) Colors, Md.			
23. FUNERAL DIRECTOR Vernon E. Mullen				ADDRESS Rising Sun, Md.				24a. REC'D BY REGISTRAR DATE OCT 6 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

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11292

CERTIFICATE OF DEATH

11287

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>1 1/2 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nelda W.</u> Middle <u>Reynolds</u> Last <u>Reynolds</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>10</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 6, 1901</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>59</u> Days <u>59</u> Hours <u>59</u> Min. <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>CHRISTIAN SCHREIVER</u>		14. MOTHER'S MAIDEN NAME <u>MINNIE JEPPE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>CLARENCE T. REYNOLDS</u>		Address <u>CHESAPEAKE CITY, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardio-vascular Dis.</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>7 con</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <u>—</u> Not while <input type="checkbox"/> of work <u>—</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8 Oct</u> , 19 <u>60</u> , to <u>10 Oct</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>10 Oct</u> , 19 <u>60</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wallace Obenshain</u>		ADDRESS (Street, city or town, state) <u>Cecilton, Md</u> DATE SIGNED <u>10 Oct 60</u>	
PHYSICIAN'S NAME (Type) <u>WALLACE OBENSHAIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>10/12/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BETHEL CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>BETHEL, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FUNERAL HOME</u>		24a. REC'D BY REGISTRAR <u>OCT 13 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>	

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11592

INSTITUTE OF HEALTH

DEPARTMENT OF HEALTH AND HUMAN SERVICES

11592

11592

1 FOR STATE HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

11297 MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12478

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Port Deposit c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 117 D Preston Drive				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland f. COUNTY Cecil c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Port Deposit d. STREET ADDRESS 117 D Preston Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Geraldine Lillian Riefer				4. DATE OF DEATH Month Day Year 10 28 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/17/36	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 24 yrs.		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME Gerald William Kuder		14. MOTHER'S MAIDEN NAME Vera M. Bird		12. CITIZEN OF WHAT COUNTRY? U.S.A.		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No	
16. SOCIAL SECURITY NO. 119-28-7015		17. INFORMANT Mrs. Vera Kuder, 142 Otis St.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pistol shot in head with laceration of brain stem also laceration of liver and both lungs. DUE TO (b) both lungs. DUE TO (c) both lungs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Was shot by her husband and beat with hammer		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Was shot by her husband and beat with hammer					
20c. TIME OF INJURY Month, Day, Year 3:30 a.m. 10/28 19 60		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Port Deposit, R.D. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE R. C. Dodson		EXAMINER'S NAME (Type) Dr. R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10/31/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 4, 1960		22c. NAME OF CEMETERY OR CREMATORY Holy Supulcher Cemetery, Rochester, New York		22d. LOCATION (City, town, or country) (State) Rising Sun, Md.	
23. FUNERAL DIRECTOR Ralph E. Hicks		ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR NOV 17 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

MEDICAL CERTIFICATION

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11307

DEPT. OF HEALTH
DIVISION OF VITAL STATISTICS

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11311

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11289

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville, Rural				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Marks Rd.				d. STREET ADDRESS St. Marks Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Leslie Middle Bruce Last Roberts				4. DATE OF DEATH Month Oct. Day 8 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 8, 1880	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 79 Days 79 Hours 79 Min. 79		IF UNDER 24 HRS. Months 79 Days 79 Hours 79 Min. 79			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Keeper		10b. KIND OF BUSINESS OR INDUSTRY U.S.V. Adm.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John B. Roberts				14. MOTHER'S MAIDEN NAME Hannah M. Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 218-32-1731		17. INFORMANT Elma W. Roberts, Perryville, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 156.1 Carcinoma of Liver DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Sigmoid		INTERVAL BETWEEN ONSET AND DEATH 1 yr		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 25 - 59 to Oct 8 - 1960 , that (I) (we) last saw the deceased alive on Oct 8 - 1960 , and that death occurred at 4:25 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Clarence I. Benson M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE 10/10/60	
22c. PHYSICIAN'S NAME (Type) Clarence I. Benson				22d. ADDRESS Port Deposit, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-12-1960		23c. NAME OF CEMETERY OR CREMATORY New London Presbyterian		23d. LOCATION (City, town, or county) (State) New London, Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son				ADDRESS Perryville, Md		25a. REC'D BY REGISTRAR DATE OCT 13 '60	
						25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

11811

11821

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH
HONOLULU, TERRITORY OF HAWAII

NAME OF DECEASED
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
AGE
SEX
RACE
RELIGION
EDUCATION
OCCUPATION
MARRIAGE
SINGLE
MARRIED
WIDOWED
DIVORCED
REMARKS

SIGNATURE OF PHYSICIAN
SIGNATURE OF MINISTER OF RELIGION
SIGNATURE OF CORONER
SIGNATURE OF WITNESSES
DATE OF ENTRY
PLACE OF ENTRY

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FOR STATE
HEALTH DEPT.
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TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 1, 2, and 3 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

11312
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11290
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 400 Jefferson	
3. NAME OF DECEASED (Type or print) JOHN FRANKLIN SMITH		4. DATE OF DEATH October 28 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 14, 1938
9. AGE (In years last birthday) 21 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter's Helper		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Annapolis, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME STANLEY D. SMITH		14. MOTHER'S MAIDEN NAME MARY AGNES ISAAC	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) PTE		16. SOCIAL SECURITY NO. 215 34 5925	
17. INFORMANT Stanley D. Smith, Sr., 400 Jefferson St. Annapolis, Md. (Father)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Decapitation of head DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) 979X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B. C. DODSON		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B. C. DODSON, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 10-28-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 11-1-1960	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Cenetery		22d. LOCATION (City, town, or country) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR JOHN TAYLOR FUNERAL HOME, Maryland		24a. REC'D BY REGISTRAR DATE NOV 1 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

11313

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11291

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 11 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. STREET ADDRESS 806 S. Ellwood Avenue	
3. NAME OF DECEASED (Type or print) First FRANK Middle J. SOBUS Last (LOBUS)		4. DATE OF DEATH Month October Day 24 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-25-99
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Janitor	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Lobus		14. MOTHER'S MAIDEN NAME Mary Rusin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW-I		16. SOCIAL SECURITY NO. 212-16-9680	
17. INFORMANT Address Baltimore, Md. Joseph Lobus, brother, 1532 Oakridge Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac tamponade DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rupture of heart due to infarction DUE TO (c) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 8-12 hrs. unknown unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. V.A. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that XXXXXX attended the deceased from October 13, 19 60 to October 24, 19 60 and that death occurred on 5:45 PM from the causes and on the date stated above.			
22a. SIGNATURE A. L. Mooney		22b. DATE SIGNED 10-25-60	
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, Asst. Clinical		22d. ADDRESS Pathologist, V.A. Hospital, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/28/60	
23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Weber & Sons Inc. 401 S. Chester St.		25a. REC'D BY REGISTRAR DATE OCT 27 '60	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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CENTRAL MOUNTAIN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

11314

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11292

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Susquehanna Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John William Thomas		4. DATE OF DEATH Month Oct. Day 16 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20, 1888
9. AGE (In years lost birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Day	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John I. Thomas		14. MOTHER'S MAIDEN NAME Alice Ritchie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-05-3944	
17. INFORMANT John C. Thomas, Perryville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Chronic Myocarditis - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio-Sclerotic INTERVAL BETWEEN ONSET AND DEATH 5 yrs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 10, 1960, to Oct. 15, 1960, that (I) (we) lost the deceased alive on Oct 15 1960, and that death occurred at 11 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Clarence I. Benson M.D.		22b. DATE SIGNED 10/17/60	
22c. PHYSICIAN'S NAME (Type) Clarence I. Benson, M.D.		22d. ADDRESS Port Deposit, Md.	
23a. BURIAL, CREMATION, OR OTHER (Specify) Burial		23b. DATE THEREOF 10-19-1960	
23c. NAME OF CEMETERY OR CREMATORY Asbury		23d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural	
24. FUNERAL DIRECTOR'S SIGNATURE Selva Patterson Wilson, Perryville, Md.		25a. REC'D BY REGISTRAR DATE OCT 19 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

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U.S. DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G273 10-14-60 et

CERTIFICATE OF DEATH

11294

Reg. Dist. No.

11293

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>			c. LENGTH OF STAY IN 1b <u>5 yrs.</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> <u>21</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home - 401 Maryland Ave.</u>				d. STREET ADDRESS <u>401 Maryland Avenue</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Frederick</u> Middle <u>Charles</u> Last <u>Tretheway</u>				4. DATE OF DEATH Month <u>October</u> Day <u>2</u> Year <u>19 60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 2, 1890</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stainless Steele Fabricator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J.B. Tretheway</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Greenley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mrs. Elmer Frey, Jr., Elkton, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis, primary source undetermined</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 18, 1960</u> to <u>Oct 2, 1960</u> , that I last saw the deceased alive on <u>Oct 2, 1960</u> , and that death occurred at <u>3 A.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1235 Singsley Ave</u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>Tillman D Johnson</u> M.D. <u> </u>				DATE SIGNED <u> </u>			
PHYSICIAN'S NAME (Type) <u>Tillman D Johnson</u>				<u>Elkton, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/5/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Shrine Cemetery, Plains, Pa.</u>		22d. LOCATION (City, town, or county) (State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E Hicks</u>				24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	
ADDRESS <u>Elkton, Md.</u>				DATE <u>OCT 7 '60</u>		<u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11584

PLACE OF DEATH		DATE OF DEATH	
HOME		JAN 10 1900	
CITY		BALTIMORE	
COUNTY		BALTIMORE	
STATE		MARYLAND	
AGE		65	
SEX		MALE	
RACE		WHITE	
OCCUPATION		FARMER	
EDUCATION		HIGH SCHOOL	
MARRIAGE		MARRIED	
RELIGION		METHODIST	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
SIGNATURE OF DECEASED		[Signature]	
SIGNATURE OF WITNESS		[Signature]	
SIGNATURE OF PHYSICIAN		[Signature]	
SIGNATURE OF CLERK		[Signature]	
SIGNATURE OF REGISTRAR		[Signature]	
SIGNATURE OF JUDGE		[Signature]	
SIGNATURE OF SHERIFF		[Signature]	
SIGNATURE OF CONSTABLE		[Signature]	
SIGNATURE OF TOWNSHIP CLERK		[Signature]	
SIGNATURE OF COUNTY CLERK		[Signature]	
SIGNATURE OF STATE CLERK		[Signature]	
SIGNATURE OF DEPARTMENT CLERK		[Signature]	

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FOR STATE HEALTH DEPT. (M)
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MEDICAL CERTIFICATION
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VS. A15ME
5M 7/59

11295
11294
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN 1b 3 1/2 hours d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Cecil c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Charles town d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Willard First Ulshafer Middle Last 4. DATE OF DEATH 10-14-60 Month Day Year			5. SEX M 6. COLOR OR RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 9-16-1900 9. AGE (In years last birthday) 60 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Powder Mixer		10b. KIND OF BUSINESS OR INDUSTRY Ordinance		11. BIRTHPLACE (State or foreign country) Sugar Loaf Pa.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Ulshafer		14. MOTHER'S MAIDEN NAME Gertrude Englehart			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 1		16. SOCIAL SECURITY NO. 216-05-3881		17. INFORMANT Mrs. William Ulshafer, Charles town. Md. Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 90% Body burned 2nd and Third Degree 917.3 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Mixing powder and was burned					
20c. TIME OF INJURY Month, Day, Year 10 12, 60 Hour 5:15 p.m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Ordinance Plant			
20f. (City or town) Elkton Rd (County) Cecil (State) Md.		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE R.C. Dodson		M.D. R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED 10-14-60		Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-17-1960		22c. NAME OF CEMETERY OR CREMATORY Charlestown Methodist			
22d. LOCATION (City, town, or country) (State) Charlestown, Cecil, Maryland		23. FUNERAL DIRECTOR Joseph R. Grant ADDRESS North East, Maryland					
24a. REC'D BY REGISTRAR OCT 17 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

VS. A15ME
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11315 CERTIFICATE OF DEATH

Reg. Dist. No. 11295

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bainbridge</u>				c. LENGTH OF STAY IN 1b <u>6 hrs, 23 min</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Station Hospital, USNTC</u>				d. STREET ADDRESS <u>111-B Preston Drive, Manor Heights</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Lou Vincent</u>				4. DATE OF DEATH Month Day Year <u>October 3 1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 3, 1960</u>	9. AGE (In years lost birthday) yrs. <u>6</u>	IF UNDER 1 YEAR Months Days <u>6 23</u>	IF UNDER 24 HRS. Hours Min. <u>6 23</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Wesley Bennett Vincent</u>				14. MOTHER'S MAIDEN NAME <u>Tokiko Oma Omae</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -----		17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PREMATURITY</u> DUE TO (c) <u>PREMATURE LABOR, RUPTURED MARGINAL SINUS</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs 23 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from <u>October 3, 1960</u> , to <u>October 3, 1960</u> , that I last saw the deceased alive on <u>October 3, 1960</u> , and that death occurred at <u>12:45 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul C Horn</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>Station Hospital, USNTC, Bainbridge, Maryland 10-4-60</u>			
PHYSICIAN'S NAME (Type) <u>P. C. HORN, LT USNR Station Hospital, USNTC, Bainbridge, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-5-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colorado Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson & Son</u>				ADDRESS <u>PERRYVILLE, MARYLAND</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 5 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

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CERTIFICATE OF DEATH

11296

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>			c. LENGTH OF STAY IN 1b <u>45 1/4 yrs</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Floyd</u> Middle <u>H. White</u> Last				4. DATE OF DEATH Month <u>10</u> Day <u>13</u> Year <u>19 60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-30-1873</u>		9. AGE (In years lost birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Penna R.R. Telegrapher</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John White</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Janney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>717-07-5747</u>		17. INFORMANT <u>Mrs Floyd H. White</u> Address <u>North East, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>5 yrs.</u>						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>59</u> , to <u>13 Oct</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>5 Oct</u> , 19 <u>60</u> , and that death occurred at <u>10 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Klaus H. Huehner</u>				ADDRESS (Street, city or town, state) <u>North East, Md</u>		DATE SIGNED <u>10/15/60</u>	
PHYSICIAN'S NAME (Type) <u>Klaus H. Huehner M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-16-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>North East, Cecil, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u>				ADDRESS <u>North East, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 17 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11316

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11297

1. PLACE OF DEATH e. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton, R.D.2. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) All life				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Md. b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, R.D.2. d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Annie		First B		Middle Wood		Last 1		4. DATE OF DEATH Month 10 Day 30 Year 19 60							
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-2-1879		9. AGE (In years less birthday) 81 yrs.		IF UNDER 1 YEAR Months 10 Days 30		IF UNDER 24 HRS. Hours 19 Min. 60			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At Home				11. BIRTHPLACE (State or foreign country) Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James S Nowland				14. MOTHER'S MAIDEN NAME Jane McCoy											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no				16. SOCIAL SECURITY NO. none				17. INFORMANT Address Robert Nowland, North East, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) General Arterio sclerosis (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE R.C. Dodson				M.D. R.C. Dodson				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 10-30-60			
EXAMINER'S NAME (Type) R.C. Dodson				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) Elkton, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 11-2-60		22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Meth. Cem.				22d. LOCATION (City, town, or country) (State) Cherry Hill, Md.					
23. FUNERAL DIRECTOR PIPPIN FUNERAL HOME				ADDRESS Elkton, Md.				24a. REC'D BY REGISTRAR NOV 4 '60				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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MR. SMITH
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